VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

January 18, 2013

Ms. Claudette Werner-Poorman, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Provider #: 475033

Dear Ms. Werner-Poorman:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **December 19, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

PRINTED: 01/03/2013
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475033	A. BUILDING _____ B. WING _____	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT MANOR CARE CTRS	312 CRESCENT BLVD BENNINGTON, VT 05201

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F 000	INITIAL COMMENTS	F 000		
F 156 SS=D	An unannounced on-site recertification survey was conducted by the Division of Licensing and Protection between 12/17/2012 and 12/19/2012. The following deficiencies were identified: 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Clarabelle Warner Coons — Administrator — 1-11-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PMC

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F 156	Continued From page 1	F 156		

facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and

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F 156	Continued From page 2 procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that 1 resident (Resident #56) of 23 identified in the sample understood what services were included in nursing facility services under the State plan for which the resident may not be charged, those items and services that the facility offers and for which the resident may or may not be charged. The findings include: 1. Per record review, Resident #56 was re-admitted to the facility on 8/3/12 with diagnoses that include dementia. Per review of	F 156	**F156** **Resident # 56 remains in the facility in stable condition.** **All residents and/or family will be informed of coverage of psychological services upon referral. The Social Worker is responsible to assure that the resident and family understand and are aware of the coverage service.** **Social Worker will complete random audits of outside services to assure that family is informed of coverage. Outcomes of audits will be presented to the CQI committee. These audits will be completed for two months to assure compliance.** **2/5/13** **On-going** F156 POC accepted 1/17/13 eColeman/PMC	

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the medical record, Resident #56 indicated to staff during an interview on 10/12/12 that Resident #56 thought he/she would be better off dead. The medical record also indicated that Resident #56 was verbally abusive at times and resistant to care. The medical record indicates Resident #56 sleeping for long periods of time and declining to participate in activities outside Resident #56's room.

Per review of the physician's orders, an order was obtained by staff on 10/15/12 for Resident #56 to be evaluated by Deer Oakes for the need for possible psychological services for Resident #56 related to behavior issues (verbally abusive, resistant to care, and potential signs of depression). The nurses notes indicate that the spouse of Resident #56 declined the offer for psychological services because the spouse indicated to staff that he/she "did not want to pay for psychological services." Per a Physician fax order, the physician indicated to staff that the spouse "would not have to pay for psychological services that they would be covered by Medicare."

Per review of the comprehensive plan of care, the behavior care plan indicates to utilize psychological services as needed.

Per review of the medical record there was no evidence that nursing staff or staff in the Social Services department educated the spouse of Resident #56 regarding what services are covered by Medicaid and what services are the responsibility of the resident and there was no documentation that indicates the spouse of Resident #56 was educated on the possible need

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F 156	Continued From page 4 for psychological services. Per interview with the Social Service Director (SSD) and the Unit Manager (UM) on 12/19/12, they confirmed that Resident #56 had indicated to staff during an interview on 10/12/12 that he/she would be better off dead. The SSD and UM also confirmed that Resident #56 was verbally abusive at times and resistant to care. Per interview the UM and SSD on 12/19/12 confirmed that there was no documentation that nursing staff or staff in the Social Services department educated the spouse of Resident #56 regarding what services are covered by Medicaid and what services are the responsibility of the resident and there was no documentation that indicates the spouse of Resident #56 was educated on the possible need for psychological services. The SSD confirmed that he/she was aware that the spouse of Resident #56 would not be expected to pay for psychological services because they would be covered by Medicare. The UM confirmed that the comprehensive care plan for behaviors indicated that the facility was to utilize psychological services as needed for Resident #56.	F 156		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225		

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F 225	Continued From page 5 other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to assure that two of four alleged violations of mistreatment or abuse in the sample (Resident #61 toward Residents #49 and #79) were thoroughly investigated and failed to prevent further abuse. Further, the facility failed to make a mandatory report of the abuse to Adult Protective Services or the State Survey and Certification Office through their established procedures and	F 225	Past noncompliance: no plan of correction required.	

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F 225	Continued From page 6 within 48 hours. Findings include: 1. Per interview with Resident #49 on 12/17/12 at 2:49 PM, Resident #61 (who has Huntington's Disease and is monitored for aggressive behaviors) punched him/her in the back of the head on a date shortly after his/her admission on 5/24/12. Record review revealed a day shift nurse's note indicating that on 6/2/12 at 1:30 PM, Resident #61 came up behind and punched Resident #49 in the back of the head/neck. A note written by the evening shift nurse on 6/2/12 noted that Resident #49 requested an ice pack due to soreness in the back of the head/neck area. Record review further revealed a fax to the primary physician on 6/2/12 reporting the details of the incident, the soreness and request of an ice pack by Resident #49. While reviewing the medical record of Resident #61, a nurse's note on 6/2/12 indicated that at 1:30 PM that day Resident #61 had hit another resident in the back of the head with a closed fist. 2. Further medical record review for Resident #61 revealed a nurse's note on 6/4/12 which stated that Resident #61 hit "another HD (Huntington's Disease) resident" in the head with a chair. This surveyor located a corresponding nurse's note on 6/4/12 in the medical record of Resident #79 (who has Huntington's Disease) which stated that Resident #79 was trying to get his/her coat off from a chair when another "HD resident" hit him/her in the head with a chair. During an interview on 12/18/12 at 12:30 PM, neither the Administrator nor the Director of Nursing (DNS) could produce evidence that the incidents of 6/2/12 and 6/4/12 had been	F 225		

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F 225	Continued From page 7 thoroughly reviewed in an internal investigation. Both the Administrator and the DNS confirmed during this interview that neither the incident of 6/2/12, nor that of 6/4/12, had been reported to Adult Protective Services (APS) or the State Survey and Certification agency. The facility's written Administrative Policies & Procedures for Resident Abuse includes language requiring reports to APS for allegations of abuse, neglect, or exploitation within 48 hours of the incident, and outlines the steps of the required internal investigation. Based on investigation during the survey process, the facility corrected this deficient practice prior to the start of the recertification survey.	F 225		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to to provide 1 resident of 2 (Resident #7) with the right to make choices about aspects of his/her life in the facility that are significant to the resident. The findings include: 1. Per direct observation during the noon meal on 12/17/12 at 12:24 PM in the main dining area on	F 242		

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F 242	Continued From page 8 the North wing, Resident #7 was eating lunch and requested from the Unit Manager (UM) to have more food. The UM indicated to Resident #7 that s/he could not have more food, that s/he was on a restricted diet and that s/he had not finished all the food in front of him/her yet. The UM indicated to Resident #7 to finish all his/her food and s/he would be full. Per direct observation Resident #7 had pie, juice, milk and coffee in front of him/her to consume. Per direct observation of Resident #7's dietary tray slip, Resident #7 had been served an omelet, pie, milk, coffee and cranberry juice for the lunch meal. The slip indicated that Resident #7 was on a 2200 calorie ADA (American Diabetic Association) diet. Per direct observation at 12:49 PM, Resident #7 again requested more food from the UM. The UM indicated to Resident #7 that s/he was on a "special diet" and the UM verbalized to Resident #7 that s/he would get him/her vegetables. Per interview with Resident #7 on 12/17/12 at 12:41 PM, s/he indicated that s/he liked the food and that s/he wanted more and s/he could not get more. Per interview with the UM and Dietary Consultant on 12/17/12 at 3:00 PM, they confirmed that Resident #7 was on a calorie restricted diet and that Resident #7 at each meal requests more food in addition to his/her normal meal. The Dietary Consultant indicated that they had worked with the physician to get a more liberal diet for Resident #7. The UM indicated that they had recently received orders from the physician to increase number of calories per day for Resident	F 242	**F242** **Resident # 7 remains in the facility in stable condition.** **All residents have select menus to choose their likes and dislikes. All residents will be given choices related to their diet when asking for additional servings.** **Staff Development will re-educate all staff on the importance of offering choices. Staff Development will complete dining room rounds to observe compliance.** **Staff Development will complete audit of observations and report findings to the CQI Committee for the next two months to assure compliance.** **2/5/13** F242 POC accepted 1/7/13 GColeman RN Pmc	

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F 242	Continued From page 9 #7 and that Resident #7 is given a glass of water prior to each meal to fill him/her up, because the physician does not want Resident #7 to consume a lot of calories. Per the UM, the UM chose the vegetables for the resident when Resident #7 asked for more at the lunch meal because the UM was trying to adhere to the physician order and give Resident #7 something healthy. The UM confirmed that the UM made the choice for Resident #7 and did not give him/her any options of what s/he might want to eat. The UM and the Dietary Consultant confirmed that Resident #7 has the right to choose his/her own food choices in accordance to the physicians dietary orders of a 2200 ADA diet and that Resident #7 was not given the choice on 12/17/19 at 12:41 PM when s/he requested additional food to eat.	F 242		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to ensure that sufficient and appropriate social services are provided to meet the needs of 1 of 23 residents reviewed (#56). The findings include: 1. Per record review, Resident #56 was	F 250		

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F 250	Continued From page 10 re-admitted to the facility on 8/3/12 with diagnoses that include dementia. Per review of the medical record, Resident #56 indicated to staff during an interview on 10/12/12 that Resident #56 thought s/he would be better off dead. Per review of the medical record, it indicated that Resident #56 was verbally abusive at times with staff and residents and resistant to care. The medical record also indicates Resident #56 sleeps for long periods of time and declines to participate in activities outside his/her room. Per review of the physician's orders, an order was obtained by staff on 10/15/12 for Resident #56 to be evaluated by Deer Oakes for the need for possible psychological services related to verbally abusive behaviors, signs of possible depression and non compliance with care. Per review of the nurses notes they indicate that the spouse of Resident #56 declined the offer for psychological evaluation for Resident #56 because the spouse indicated to staff that he/she "did not want to pay for psychological services." Per review of a Physician fax order dated 10/15/12 the physician indicated to staff that the spouse of Resident #56 that he/she "would not have to pay for psychological services (from Deer Oakes) that the services would be covered by Medicare." Per review of the comprehensive plan of care, the behavior care plan indicates to utilize psychological services as needed. Per review of the medical record there was no evidence that nursing staff or staff in the Social Services department educated the spouse of	F 250		

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F 250	Continued From page 11 Resident #56 regarding what is services are covered by Medicaid and what services are the responsibility of the resident and there was no documentation that indicates the spouse of Resident #56 was educated on the possible need for psychological services. Per interview with the Social Service Director (SSD) confirmed that Resident #56 had indicated to facility staff during an interview on 10/12/12 that Resident #56 thought he/she would be better off dead. The SSD and UM also confirmed that Resident #56 was verbally abusive at times with staff and other residents and resistant to care. Per interview the UM and SSD on 12/19/12 they confirmed that there was no documentation that nursing staff or staff in the Social Services department educated the spouse of Resident #56 regarding what is services are covered by Medicaid and what services are the responsibility of the resident to pay for. The SSD also confirmed there was no documentation that indicates the spouse of Resident #56 was educated on the possible need for Resident #56 to receive psychological services after 10/15/12. The SSD confirmed that he/she was aware that the spouse of Resident #56 would not be expected to pay for psychological services that they would be covered by Medicare. The SSD confirmed that the comprehensive care plan for behaviors indicated that the facility was to utilize psychological services as needed for Resident #56.	F 250	**F250** **Resident # 56 remains in the facility in stable condition.** **All residents and/or family will be informed of coverage of psychological services upon referral. The Social Worker is responsible to assure that the resident and family understand and are aware of the coverage service.** **Social Worker will complete random audits of outside services to assure that family is informed of coverage. Outcomes of audits will be presented to the CQI committee. These audits will be completed for two months to assure compliance.** F250 POC accepted 1/17/13 GColemanRN/PMC	**2/5/13 On-going**
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's	F 279		

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F 279	Continued From page 12 comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based upon record review and staff interview, the facility failed to develop comprehensive care plans for 2 of 3 residents that include measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment related to a decline in bladder control (Resident #8) and discharge planning (Resident #56). Findings include: 1. Per record review and confirmed with the Director of Nursing (DNS) on 12/19/12 at 12:50 PM, a plan of care was not developed to address Resident #8's decline in bladder control from 8/14/12 to 11/28/12. Per review of the	F 279		

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F 279	Continued From page 13 comprehensive assessment, on 8/14/12 Resident #8 was continent of urine (able to control urinary discharge) and on 11/28/12 was occasionally incontinent of urine (unable to control urinary discharge). Per review of the "Continence Assessment" dated 7/6/12, Resident #8 was "Continent" and the "Continence Assessment" dated 11/27/12 indicates the current treatment plan is for "absorbent products - his/her preference". In addition, the "Continence Management Scoring Tool" dated 11/27/12 states Resident #8's Total Score is 11 and that a score of 6 -11 indicates a candidate for toileting schedule (toileting schedule with incontinence care as needed). 2. Per record review on 12/19/12, Resident #56 was re-admitted to the facility with diagnoses that include dementia. Per review of the Social Service documentation dated 8/2/12, Resident #56 is to be admitted to the facility on 8/3/12 for Long term care placement on the dementia unit. Per the Social Service documentation dated 8/8/12 the family of Resident #56 indicated to staff that the drive to the facility from Brandon is too long and are requesting alternative placement in the Brandon area of Vermont. Per interview with the Unit Manager (UM) on 12/19/12, he/she indicated that Resident #56 was awaiting possible transfer to another facility related to increases in behavior issues. Per review of the Comprehensive Admission Assessment (MDS) the disposition for Resident #56 indicates long term care placement. The MDS dated 11/6/12 indicates that the disposition	F 279	**F#279** **Resident #8 is currently in the hospital and expected to return.** **The facility will use the Caretracker System "Continency Report". This report will be reviewed monthly by the Nurse Managers to audit and verify the accuracy of the Care Plan.** **Outcomes of audits will be presented at the CQI Meeting. These audits will be completed for the next two months to assure accuracy. If compliance is not met the audits will continue.** **2/5/13** **On-going** **Resident # 56 remains in the facility in stable condition.** **All Care Plans will be reviewed by the Staff Development Assistant to assure each resident has a documented discharge plan. MDS will assure that all plans are revised as needed. Staff Development Assistant will present outcomes to the CQI committee until compliance is met.** **2/5/13** F279 POC accepted 1/17/13 GColeman RN/ PMC	

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F 279	Continued From page 14 for Resident #56 is uncertain, that the resident upon interview indicates a desire to return to the community. Per review of the comprehensive care plan specific to the needs of Resident #56, there is no developed discharge care plan indicating the placement of Resident #56 to long term care with a plan to possibly discharge Resident #56 to another facility closer to family and for stated behavior issues. Per interview with the Social Service Director (SSD) and the UM on 12/19/12, the SSD confirmed that Resident #56 was originally admitted to the facility for long term care placement on the dementia unit and after several conversations with family, the facility has been looking into alternative placement in another facility that would be closer to Resident #56's family. The SSD confirmed that the the specific needs for Resident #56 regarding discharge planning were not clear and that there was no developed care plan to address Resident #56's discharge needs.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280		

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physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to review and revise the Plan of Care to reflect current needs for 2 of 23 residents (Resident # 56 & 48) The facility further failed to ensure that Resident #56 was allowed to participate in care planning or making changes in care and treatment. The findings include:

1. Per record review, Resident #48, whose diagnoses include dementia with delusions, has a Plan of Care that includes: Risk for Falls and Injury related to poor safety awareness, unsteadiness, and history of falls.

Per record review of Nursing Notes for Resident #48 and confirmed by the Charge Nurse on Resident #48's unit on 12/19/12 at 10:40 A.M., the resident experienced falls on 9/16/12, 10/20/12, and 12/16/12. Per record review, the facility's "Fall Prevention and Protocol Guidelines" states after a resident experiences a fall "Document the fall in the nursing notes and update the care plan". During the 12/19/12 interview, the Charge Nurse stated the resident's

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F 280	Continued From page 16 Care Plan is to be reviewed/revised after each fall to assess the causes and implement interventions to prevent further falls. Then the review and/or the revision is recorded on the resident's Care Plan. Per interview on 12/19/12 at 10:40 A.M., the Charge Nurse stated reviews or revisions should have but "were not done", and confirmed that there was no documentation on Resident #48's Care Plan for Risk of Falls and Injury, that indicated it had been reviewed or revised after each of the 3 separate falls. 2. Per Stage 1 interview with Resident #56 on 12/17/12, Resident #56 indicated that s/he was not able to participate in his/her care planning. Per review of the medical record on 12/19/12, the Social Services (SS) notes dated 8/28/12 and the nursing notes dated 11/13/12, indicate that Resident #56's spouse attended care plan meetings to discuss care for Resident #56. Per review of the documentation there was no evidence in the nurses notes or Social Service notes that Resident #56 had been invited to participate in these meetings or that Resident #56 was invited but refused to participate in the care planning meetings. Per review of the admission assessment dated 8/10/12, the assessment indicated that Resident #56 was oriented on admission. Review of the medical record indicated that Resident #56 has a diagnosis of dementia but was alert and oriented and able to make needs known. The review of	F 280	**F #280** **Resident # 48 remains in the facility in stable condition.** **The Falls Committee reviews all falls. The Staff Development Coordinator will re-educate all Nursing Staff on the importance of documenting interventions to prevent falls on the Care Plan.** **Nurse Managers will review care plans after the Falls Committee meeting to assure compliance. Outcomes will be presented to the CQI Committee.** **2/5/13** **Resident #56 remains in the facility in stable condition.** **MDS Assistant will be responsible to invite each resident to the Care Conference. Documentation of attendance or refusal will be documented in the resident's record.** **Random audits will be completed by Controller to assure compliance. Outcomes will be reported to the CQI Committee.** **2/5/13**	

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F 280	Continued From page 17 the admission paperwork indicates that Resident #56 has a spouse involved in his/her care. There was no documentation in the medical record that Resident #56 has been deemed incompetent and unable to make own decisions regarding care. Per interview with the Social Service Director (SSD) on 12/19/12, s/he confirmed that Resident #56 is able to make his/her own decisions regarding care. The SSD confirmed after review of the medical record documentation that there was no evidence that Resident #56 had been invited to participate in his/her care planning since admission on 8/3/12. Per interview the SSD indicated that s/he believes that Resident #56 had verbally been invited and refused to participate but was unable to provide documentation to verify this. 3. Per direct observation on 12/19/12 from 0800 AM through 12:30 PM, Resident #56 was observed to not be utilizing his/her bilateral hearing aides. Per review of the medical record, Resident #56 has bilateral hearing loss and needs to utilize bilateral hearing aides. Per review of the comprehensive care plan titled "Alteration in sensory-perception: vision and hearing", the staff is to "encourage regular use of bilateral hearing aides." Per review of the nurses notes there was no documentation that indicated that Resident #56 was being encouraged to utilize his/her hearing aides on a regular basis. Per interview with the Licensed Practical Nurse (LPN) he/she indicated that Resident #56 had hearing aides. The LPN observed Resident #56	F 280	**Resident #56 remains in the facility in stable condition.** **Residents who require hearing aids will be encouraged by staff to wear them. Documentation of usage or refusal will be noted on the residents MAR/Treatment sheets.** **To assure compliance audits will be completed by the Nurse Manager. To verify the documentation of usage or refusal. Outcome of audits will be presented to the CQI committee.** **2/5/13**	

F280 POC accepted 1/17/13
GColeman RN/PMC

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F 280	Continued From page 18 at 12:00 PM in the activity room and confirmed that Resident #56 did not have his/her bilateral hearing aides in his/her ears. The LPN indicated that Resident #56 "only wears [his/her] hearing aides when [his/her] spouse visits." Per review of the care plan the LPN confirmed that the care plan indicated that staff is to encourage regular use of bilateral hearing aides. Per interview with the Unit Manager (UM) on 12/19/12 at approximately 2:00 PM, he/she confirmed after review of the nurses notes the notes did not reflect encouragement by staff for Resident #56 to wear his/her bilateral hearing aides. The UM confirmed after review of the comprehensive care plan that the care plan had not been revised to reflect the current status of Resident #56 and that Resident #56 only utilizes his/her bilateral hearing aides when his/her spouse is visiting.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on direct observation, record review and staff interview the facility failed to arrange for services provided to 1 resident of 23 reviewed (Resident #56) provided by qualified persons in accordance with each resident's written plan of care. The findings include:	F 282		

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1. Per interview on 12/17/12 during Stage 1 of the survey, Resident #56 indicated that he/she "did not receive anything to drink in-between meals."

Per review of the medical record, Resident #56 is at risk for dehydration and has an order for Intake (of fluids and food) and Output to be monitored. Per review of the nursing assessment Resident #56 is independent with meals.

Per review of the comprehensive plan of care dated 11/3/12 and titled "At risk for fluid volume deficit related to variable PO [by mouth] fluid intake", the care plan indicates that Resident #56 is to have intake and output monitored as indicated and encourage PO fluid intake to at least 1000-1500 milliliters (ml) per 24 hours and for staff to offer a variety of fluids at regular intervals throughout the day.

Per observation from 12/17/12 through 12/19/12, no fluids were offered to Resident #56 between meals and no fluids were noted at the resident bedside. Per continuous direct observation on 12/19/12 from 0800 AM through 1203 PM, no fluids were noted at the bedside of Resident #56 and no staff offered Resident #56 any fluids during the time frame of 0800 AM through 1203 PM.

Per review of the intake and output detail report for 11/17/12 to 12/18/12 the report indicates that intake of fluids is to be documented on each shift, the report also indicates when resident refuses fluids. Per review of the fluid intake on all three shifts, there was no evidence that Resident #56 received or was offered any fluids on the over night shift (11pm to 6am). There was also no

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F 282	Continued From page 20 evidence that Resident #56 refused fluids. The report also indicated that Resident #56 received the following fluid amounts in a 24 hour period 12/13 (820ml), 12/14 (840ml), 12/15 (840ml), and 12/17/12 (600ml). Resident #56 did not receive the minimal amount of fluid required in 24 hours as per the care plan (1000 ml). There was no documentation in the nurses notes or the intake and output detail report that Resident #56 had been offered fluids and refused them on 12/13, 12/14, 12/15 and 12/17/12. Per interview with the Unit Manager (UM) on 12/19/12, the UM confirmed that Resident #56 was at risk for dehydration and after the UM reviewed the care plan for Resident #56 he/she confirmed that the care plan indicates that Resident #56 is to have intake and output monitored as indicated and encourage po fluid intake to at least 1000-1500 ml/24 hours and for staff to offer a variety of fluids at regular intervals throughout the day. Per interview the UM, he/she confirmed after review of the nurses notes from 11/17 to 12/17/12 that there was no documentation that staff had encouraged fluid consumption by Resident #56 and that there was no documentation in the Nurses notes from 11/17/12 to 12/17/12 that Resident #56 has refused any fluids that were offered. Per interview with the UM, he/she indicated that there was no documentation of staff offering Resident #56 fluids on the third shift during the time frame from 11/17/12 to 12/17/12 and the UM indicated that he/she knew that Resident #56 was awake on the third shift and was consuming fluids. The UM confirmed after review of the intake report that Resident had not met the daily requirement for fluid consumption of at least 1000 ml in a 24 hour	F 282		

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period on 12/13, 12/14, 12/15, and 12/17/12.

2. Per direct observation on 12/19/12 from 0800 AM through 1230 PM, Resident #56 was observed to not be utilizing his/her bilateral hearing aides.

Per review of the medical record, Resident #56 has bilateral hearing loss and needs to utilize bilateral hearing aides. Per review of the comprehensive care plan titled "Alteration in sensory-perception: vision and hearing", the staff is to "encourage regular use of bilateral hearing aides." Per review of the nurses notes there was no documentation that indicated that Resident #56 was being encouraged to utilize his/her hearing aides on a regular basis.

Per interview with the Licensed Practical Nurse (LPN) he/she indicated that Resident #56 had hearing aides. The LPN observed Resident #56 at 12:00 PM in the activity room and confirmed that Resident #56 did not have his/her bilateral hearing aides in his/her ears. The LPN indicated that Resident #56 "only wears his/her hearing aides when his/her spouse visits." Per review of the care plan the LPN confirmed that the care plan indicated that staff is to encourage regular use of bilateral hearing aides.

Per interview with the Unit Manager (UM) on 12/19/12 at approximately 2:00 PM, he/she confirmed after review of the nurses notes the notes did not reflect encouragement by staff for Resident #56 to wear his/her bilateral hearing aides.

F282
Resident #56 remains in the facility in stable condition.

1.

SDC will complete in-service to all nursing staff on the importance of documentation of fluid in takes. The Caretracker System Fluid Intake reports will be used to alert the Nurse Managers as to residents at risk for low fluid intake. Nurse Managers will address issues regarding low intakes. Compliance of documentation will be assured by audits completed by Nurse Managers and presented to the CQI Committee. These audits will continue for three months to assure documentation is completed.

2/3/13

2.
Residents who require hearing aids will be encouraged by staff to wear them. Documentation of usage or refusal will be noted on the residents MAR/Treatment sheets.

To assure compliance audits will be completed by the Nurse Manager. To verify the documentation of usage or refusal. Outcome of audits will be presented to the CQI committee.

2/3/13

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F 282	Continued From page 22 3. Per review of the medical record, Resident #56 indicated to staff during an interview on 10/12/12 that Resident #56 thought he/she would be better off dead. The medical record also indicated that Resident #56 was verbally abusive at times with staff and residents and resistant to care. The medical record indicates Resident #56 sleeps for long periods of time and declines to participate in activities outside Resident #56's room. Per review of the physician's orders an order was obtained by staff on 10/15/12 for Resident #56 to be evaluated by Deer Oakes for the need for possible psychological services related to verbally abusive behaviors, signs of possible depression and non compliance with care. Per review of the nurses notes the notes indicate that the spouse of Resident #56 declined the offer for psychological evaluation for Resident #56 because the spouse indicated to staff that he/she "did not want to pay for psychological services." Per review of a Physician fax order dated 10/15/12 the physician indicated to staff that the spouse of Resident #56 that he/she "would not have to pay for psychological services (from Deer Oakes) that the services would be covered by Medicare." Per review of the comprehensive plan of care, the behavior care plan indicates to utilize psychological services as needed. Per review of the medical record there was no evidence that nursing staff or staff in the Social Services department educated the spouse of Resident #56 regarding what is services are covered by Medicaid and what services are the	F 282	~~F250~~ **Resident # 56 remains in the facility in stable condition.** **All residents and/or family will be informed of coverage of psychological services upon referral. The Social Worker is responsible to assure that the resident and family understand and are aware of the coverage service.** **Social Worker will complete random audits of outside services to assure that family is informed of coverage. Outcomes of audits will be presented to the CQI committee. These audits will be completed for two months to assure compliance.** F282 POC accepted 1/17/13 G.ColemanRN/PMC	**2/5/13 On-going**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475033	A. BUILDING _____ B. WING _____	12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT MANOR CARE CTRS	312 CRESCENT BLVD BENNINGTON, VT 05201

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F 282	Continued From page 23 responsibility of the resident and there was no documentation that indicates the spouse of Resident #56 was educated on the possible need for psychological services. The SSD confirmed that the comprehensive care plan for behaviors indicated that the facility was to utilize psychological services as needed for Resident #56.	F 282	*This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Crescent Manor Care Center does not admit that the deficiencies CMS2567 exist, nor does the facility admit to any statement findings, facts, or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal proceedings all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.*	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AH
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475033	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT MANOR CARE CTRS	312 CRESCENT BLVD BENNINGTON, VT

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 278	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to assure the assessment accurately reflects each resident's status for 1 of 23 residents (Resident #48). Findings include:

1. Per record review of Nursing Notes for Resident #48 and confirmed by the Charge Nurse on Resident #48's unit on 12/19/12 at 10:40 A.M., the resident experienced a fall on 9/16/12 and again on 10/20/12. Per record review of Resident #48's Minimum Data Sheet (MDS) dated 10/27/12, required by the Centers for Medicare and Medicaid, states under 'Health Conditions - FALLS:
'Any [falls] since admission/entry/reentry or prior assessment? [prior assessment 7/27/12] Answer: No.'

Per interview with Resident #48's Charge Nurse on 12/19/12 at 10:40 A.M. Resident #48's medical record documents 2 falls between the MDS assessment on 7/27/12 and the most recent MDS on 10/27/12. The Charge Nurse confirmed the MDS falls information was not accurate, and stated the 2 falls "should be marked" on the 10/27/12 MDS but "were not".

AH
"A" FORM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 475033	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 12/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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